Small Smiles Pediatric Dentistry - Patient Information

Date:_____ Patient Name:_____(Preferred):_____

D.O.B (Day/Month/Year):_____ Male:_____ Female:_____

Name of person completing this form: _____

Relationship to patient: Parent:____ Guardian:____ Other:_____

Home Address:_____ City:_____

Province:_____ Postal Code:_____ Home Phone Number:_____

Cell Phone Number:_____ Work Phone Number:_____

Email Address:_____ AHC#:_____

Mother's Name:_____ Father's Name:_____

Physician:_____ Referred By:_____

Dental Insurance (Father/Mother)

Insurance Company:_____

Employer Name:_____

Group/Policy Number:_____

Certificate #:_____ ID#:_____

D.O.B (DD/MM/YY):_____

Dental Insurance (Mother/Father)

Insurance Company:_____

Employer Name:_____

Group/Policy Number:_____

Certificate #:_____ ID#:_____

D.O.B (DD/MM/YY):_____

CREDIT CARD INFORMATION

Credit card # _____ Exp_____ Cvc _____

MEDICAL HISTORY

___ Yes ___ No Is your child allergic to anything?_____

___ Yes ___ No Is your child in good health? Last medical exam: _____

___ Yes ___ No Is your child taking any medication? If yes, please provide medication and dose:_____

___ Yes ___ No Have you ever been told your child needs to take antibiotics before dental treatment?

___Yes ___ No Has your child ever been hospitalized, had general anesthesia or emergency room visits? Is yes please explain:_____

___Yes ___ No Any difficulties at birth or pre-mature?_____

Please circle if your child has or has been treated for any of the following:

Asthma	Blood Disorder	Defiance disorder	Mental delays
ADHD	Cleft lip/palate	Endocrine/growth	Physical delays
Anemia	Cerebral Palsy	Eyesight	Sickle cell disease
Arthritis	Cancer/Tumor	Gastric Disease/reflux	Speech/hearing
Autism	Congenital birth defect	Heart Disease	Seizures
AIDS/HIV	Celiac	Heart Murmur	Snoring
Adverse drug reaction	Diabetes	Hepatitis	Tonsil/adnoid problems
Bleeding/transfusions	_____Syndrome	Kidney disease	Tuberculosis

Other:_____

DENTAL HISTORY

The reason for your child's visit?_____

___Yes ___No Is this your child's first dental visit? If no, date of last visit:_____

___Yes ___No Has your child experienced any unfavourable reaction from previous dental care? If yes explain:_____

___Yes ___No Does your child suck a finger, thumb or pacifier?

___Yes ___No Does your child go to bed with a bottle or sippy cup?

___Yes ___No Has your child ever injured teeth? Which teeth?_____

___Yes ___No Has your child had local anesthetic? Any problems?_____

Please circle if your child is having problems with any of the following:

Cavities	Toothache	Sensitive teeth	Mouth breathing
Trauma	Gum Infections	Color of teeth	Other:_____
Orthodontics	Jaw Sounds	Grinding	

CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Dr. Omar Mohammad and staff to examine, clean and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic purposes. I understand that dental treatment for children includes efforts to guide their behaviour by helping them understand the treatment in terms appropriate for their age. Dr. Mohammad will provide an environment that will help your child learn to cooperate during treatment including praise, explanations and demonstrations of procedures and instruments. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Dr. Mohammad of any changes in my child's medical status.

Legal Guardian Signature:_____ **Date:**_____